TULIP TREE
FAMILY HEALTH CARE

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL/BEHAVIORAL HEALTH INFORMATION

Patient Name:_____ DOB:_____ SSN:_____

Address:_____ City_____ ST_____ ZIP_____
Phone No._____

I authorize the release of my information between the two parties as indicated below:

Tulip Tree Family Health Care (All Providers) 123 N McCreary St Fort Branch IN 47648-1313 And/or 108 N Main St Princeton IN 47670 PH# 812-753-1039 **Fax # 812-753-1122** May Share My Information □ YES □ NO	Name of Person of Agency Address City/State/Zip Phone #/Fax # May Share My Information □ YES □ NO
☐ Obtain from ☐ Release to	☐ Obtain from ☐ Release to

Please release the following information:

____Treatment Plan notes & Information
____ Medications
____ Billing & Eligibility Records
____ X-Rays/Reports/Lab Results
____ Admission/Discharge & Operation Reports
____ Diagnostic Assessments
____ Psychotherapy Notes ONLY
____ HIV/AIDS/STD Treatment
____ Demographics, Billing & Eligibility Records *
____ Alcohol/Drug Abuse Treatment/Referral

Dates of Treatment:_From_____To_____ (If not selected dates open to all dates)

Reason to release requested information:___ Follow-up Care(no charge) ___Continuing Care(no charge)
____ Legal Purpose ___ Insurance/Billing (no charge) ____Leaving practice (why_____)

- I can cancel this agreement at any time in writing, but my cancellation will not include information that has already been shared or obtained using this form.
- I understand information about any of the above approved topics may be shared based on this signed agreement: Behavioral Health, HIV/AIDS, Communicable Diseases, Genetic Testing and/or substance use disorder(s) and information may be re-released with the exception of substance use disorder.
- I understand I am not required to sign this form as a condition of payment, enrollment, or eligibility. I will not be refused treatment unless treatment is dependent on providing information to the party listed above.
- I understand information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.
- I understand I have the right to receive a copy of this form.
- I understand a copy of this form (including a fax) is considered as valid as the original

***My signature below means I understand and accept the terms of this form**

_____
Signature of Patient Date
*This authorization will expire one (1) year from the date signed

_____
Signature of Authorized Person/Relation Date

_____
Signature of Witness Date